

Affordable Care Act (ACA) and the Appropriations Process: FAQs Regarding Potential Legislative Changes and Effects of a Government Shutdown

Updated October 2, 2013

Congressional Research Service

<https://crsreports.congress.gov>

R43246

Contents

Introduction	1
Background on the Affordable Care Act	2
(1) How does the ACA reform the private health insurance market and expand health insurance coverage?	2
(2) How does ACA implementation affect federal spending?	3
(3) To date, what changes to the ACA have been enacted into law?	5
ACA and the Annual Appropriations Process.....	6
(4) Can an enacted appropriations law make substantive changes to prior laws?.....	6
(5) Does a funding restriction on enforcement of a particular law suspend that law?	7
(6) How long is a provision in an appropriations act effective?.....	7
(7) How might House and Senate procedural rules specific to considering appropriations measures affect the inclusion of language that repeals, defunds, or otherwise amends the ACA?	8
Potential Impact of a Shutdown on ACA Implementation	10
(8) What will happen to ACA implementation during a government shutdown?	10
(9) Are there alternative sources of funding to implement the ACA in the absence of appropriated funds for FY2014?	10
(10) In the absence of FY2014 appropriated funding, will some ACA-related activities continue during a government shutdown? If so, how will these decisions be made?	12

Tables

Table A-1. Enacted Authorizing Legislation That Amends the ACA	18
Table A-2. ACA-Related Provisions in Annual Appropriations Acts, FY2011-FY2013.....	20

Appendixes

Appendix A. Laws that Repeal or Amend Provisions of the Affordable Care Act.....	17
--	----

Contacts

Author Information.....	21
-------------------------	----

Introduction

Congress has yet to complete legislative action on any of the 12 regular appropriations bills to fund the routine operations of federal agencies for FY2014, which began on October 1, 2013.¹ Moreover, lawmakers have been unable to agree on a continuing appropriations bill, or continuing resolution (CR),² to provide funding for part or all of the new fiscal year. As a result, the federal government has begun a shutdown of programs that lack budget authority³ to continue operations in FY2014, except in certain circumstances.⁴

Congress is deeply divided over implementation of the Patient Protection and Affordable Care Act (ACA),⁵ the health reform law enacted in March 2010. Some lawmakers opposed to the ACA have advocated the use of the appropriations process to eliminate funding for the law or to delay its implementation. On September 20, 2013, the House approved an FY2014 CR (H.J.Res. 59) to provide temporary funding for the federal government until December 15, 2013. H.J.Res. 59, as passed by the House, incorporated language that would prohibit the use of any federal funds to carry out the ACA. The Senate amendment to H.J.Res. 59 did not incorporate the House ACA defunding language. The House then proposed changes to the Senate amendment to delay the ACA's implementation, but the Senate rejected those changes. With the two chambers unable to reach agreement on H.J.Res. 59 by October 1, 2013, the government commenced a partial shutdown of its operations.

The Office of Management and Budget (OMB) has posted agency shutdown plans (also called contingency plans) on its website.⁶ These plans may be modified and re-posted. Some press outlets have reported on the contents of these plans and their potential implications for agency activities.⁷

¹ Under current practice, each House and Senate Appropriations subcommittee typically drafts one regular appropriations bill for the activities under its jurisdiction, for a total of 12 bills each fiscal year. The full Appropriations Committee considers and reports each bill to the House. For further information on the status of FY2014 appropriations legislation and enacted laws, see the CRS Appropriations Status Table: FY2014, available at <http://www.crs.gov/pages/AppropriationsStatusTable.aspx>. Consolidated appropriations measures, sometimes referred to as "omnibus bills," where two or more of the regular bills are combined into one legislative vehicle, have also been enacted in prior fiscal years. For further information, see CRS Report RL32473, *Omnibus Appropriations Acts: Overview of Recent Practices*, by Jessica Tollestrup.

² Continuing appropriations acts are generally enacted in the form of joint resolutions, which is why such acts are referred to as continuing resolutions (or CRs).

³ Appropriations bills provide agencies with budget authority, which is the legal authority to incur financial obligations (e.g., hire employees, purchase services, award grants, or sign contracts) that result in immediate or future government expenditures (or outlays). For further explanations of these terms, see U.S. Government Accountability Office (hereinafter GAO), *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, pp. 20-21, available at <http://www.gao.gov>.

⁴ These exceptions are discussed in more detail in the answer to question 10 in this report. For additional information, see CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*, coordinated by Clinton T. Brass<CrsProductRef includeAuthors="true" productCode="RL34680" prodVerID="424649" title="Shutdown of the Federal Government: Causes, Processes, and Effects" url="http://www.crs.gov/pages/Reports.aspx?PRODCODE=RL34680" /><http://www.crs.gov/pages/Reports.aspx?PRODCODE=RL34680>.

⁵ The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended multiple health care and revenue provisions in the ACA. All references to the ACA in this report refer to the law as amended by HCERA.

⁶ See <http://www.whitehouse.gov/omb/contingency-plans>.

⁷ See, for example, at WashingtonPost.com, "Impact of a Government Shutdown," <http://www.washingtonpost.com/>

The current legislative debate over using the FY2014 appropriations process to defund or delay implementation of the ACA has prompted a number of questions about the law's core health reform provisions and how their implementation affects federal spending. Questions have also been raised about the legislative actions already taken by lawmakers to amend the ACA, and about the various legal and procedural considerations arising from the current efforts to use the appropriations process to defund or delay the law. Finally, there is the question of what impact a government shutdown will have on ACA implementation. This report, which will be revised and updated to reflect key legislative developments, provides brief answers to these questions.

Background on the Affordable Care Act

(1) How does the ACA reform the private health insurance market and expand health insurance coverage?⁸

Among its many provisions, the ACA reforms the private health insurance market and sets minimum standards for health coverage. The law creates competitive private health insurance marketplaces—or exchanges—in each state through which individuals and small employers will be able to shop for, select, and enroll in qualified health plans. The exchanges began open enrollment on October 1, 2013. Insurance coverage bought through the exchanges will begin on January 1, 2014. Plans offered through the exchanges, and certain other plans, must meet essential health benefit standards requiring them to cover emergency services, hospital care, physician services, preventive care, prescription drugs, and mental health and substance use disorder treatment, among other specified services.

Refundable tax credits will be available to certain individuals and families with incomes between 100% and 400% of the federal poverty level (FPL) to help offset the cost of purchasing insurance coverage through the exchanges. In addition, certain individuals and families receiving the premium credit will be eligible for a subsidy to lower their cost-sharing (i.e., out-of-pocket costs such as deductibles and co-pays).

The ACA also establishes new federal requirements for private health insurance, some of which have already taken effect. For example, health plans may not deny coverage to children up to age 19 based on a preexisting condition, young adults up to age 26 generally must be allowed to remain on their parents' health plans, and plans must cover preventive services and immunizations recommended by various specified entities without any cost-sharing. The remaining health insurance requirements take effect in 2014 when health plans will be required to sell and renew policies to all individuals, and may not deny coverage for preexisting conditions at any age or otherwise discriminate based on health status. Premiums may vary by limited amounts, but only based on age, family size, geographic area, and tobacco use.⁹

wp-srv/special/politics/2013-shutdown-federal-department-impact/; and "Government Shutdown: What's Open, What's Closed," <http://www.washingtonpost.com/wp-srv/special/politics/whats-open-whats-closed/>.

⁸ The information provided in the answer to this question is drawn from CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead. While a detailed examination of the ACA is beyond the scope of this report, numerous CRS products that provide more in-depth information on the many new programs and activities authorized and funded by the law are available at <http://www.crs.loc.gov> (see under "Issues Before Congress: Health").

⁹ For more information, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

Also beginning in 2014, most U.S. citizens and legal residents will be required to have health insurance. Those who remain uninsured may have to pay a penalty. As plans will no longer be able to restrict coverage of individuals with health problems, the ACA's individual insurance mandate is intended to ensure that healthy individuals participate in the insurance market rather than waiting until they need health care services. Increasing the number of healthy persons in the risk pool helps spread the risk.

In addition to expanding access to private health insurance coverage, the ACA, as enacted, requires state Medicaid programs to expand coverage to all eligible nonelderly, non-pregnant individuals under age 65 with incomes up to 133% of the FPL. The federal government will initially cover 100% of the expansion costs, phasing down to 90% of the costs by 2020. As enacted, Medicaid law would have allowed the Secretary of Health and Human Services (HHS) to withhold existing federal Medicaid matching funds if states refused to comply with the expansion. However, in *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court found that the Medicaid expansion unconstitutionally coerced the states by threatening them with the loss of their existing federal Medicaid matching funds.¹⁰ The Court precluded the HHS Secretary from penalizing states that choose not to participate in the Medicaid expansion, a decision that effectively makes Medicaid expansion an option for states.¹¹

(2) How does ACA implementation affect federal spending?

Implementation of the ACA is projected to have a significant impact on both discretionary and direct spending. Discretionary spending is both controlled and funded through the annual appropriations process. It typically covers the routine costs of running federal agencies and offices, including wages and salaries.¹² Direct spending—also referred to as mandatory spending—is controlled through authorizing laws.¹³ It includes spending on entitlement programs such as Medicare and Social Security. Such spending may be funded through provisions in the authorizing law that contains temporary or permanent appropriations for that purpose. Alternatively, when the authorizing law contains no appropriations, such mandatory programs are funded through the annual appropriations process. This is sometimes referred to as “appropriated mandatory” or “appropriated entitlement” spending.¹⁴

To answer this question, it is helpful to organize spending on ACA implementation into three broad categories:

¹⁰ *NFIB v. Sebelius*, No. 11-393, slip op. (June 28, 2012), <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

¹¹ For more information, see CRS Report R42367, *Medicaid and Federal Grant Conditions After NFIB v. Sebelius: Constitutional Issues and Analysis*, by Kenneth R. Thomas.

¹² For further information on discretionary spending, see CRS Report R42388, *The Congressional Appropriations Process: An Introduction*, by Jessica Tollestrup.

¹³ An authorization may generally be described as a statutory provision that defines the authority of the government to act. It can establish or continue a federal agency, program, policy, project, or activity. Further, it may establish policies and restrictions and deal with organizational and administrative matters. It may also explicitly authorize subsequent congressional action to provide appropriations. For further information, see CRS Report R42098, *Authorization of Appropriations: Procedural and Legal Issues*, by Jessica Tollestrup and Brian T. Yeh.

¹⁴ For further information on direct spending see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

Direct (Mandatory) Spending on Expanding Insurance Coverage

This category, which accounts for most of the projected federal spending under the ACA, includes the exchange subsidies (i.e., premium tax credits and cost-sharing subsidies), the federal government's share of the costs of Medicaid expansion, and tax credits for small employers. In its March 2010 estimates of the federal budgetary impact of the ACA, the Congressional Budget Office (CBO) projected that insurance coverage expansion under the ACA would cost \$938 billion over the 10-year period FY2010-FY2019. The CBO further projected that those costs would be largely offset by revenues from new taxes and fees established in the ACA, and by savings from the law's changes to Medicare payments that are designed to slow the growth in future spending on this program.¹⁵

Direct (Mandatory) Spending for Other Programs

The ACA included multiple provisions financed with appropriations in the ACA that provide billions of dollars of direct spending to support new and existing grant programs and other activities.¹⁶ For example, the law provided funding for several temporary insurance programs for targeted groups, including a temporary high-risk pool for uninsured individuals with preexisting conditions, and a reinsurance program to reimburse employers for a portion of the health insurance claims' costs for their 55- to 64-year-old retirees. It provided funding for grants to states to plan and establish health insurance exchanges. The ACA also provided a permanent appropriation, available for 10-year periods, for the Centers for Medicare & Medicaid Services (CMS) to test and implement innovative health care payment and service delivery models.

In addition, the ACA created four special funds and appropriated amounts to each one. First, the Community Health Center Fund (CHCF) is providing \$11 billion over five years to help support community health center operations and the National Health Service Corps. Second, the Patient-Centered Outcomes Research Trust Fund (PCORTF) is supporting comparative effectiveness research through FY2019 with a mix of appropriations and transfers from the Medicare trust funds. Third, the Prevention and Public Health Fund (PPHF), for which the ACA provided a permanent annual appropriation, is intended to support prevention, wellness, and other public health-related programs and activities authorized under the Public Health Service Act (PHSA). Finally, the Health Insurance Reform Implementation Fund (HIRIF), for which the ACA appropriated \$1 billion, is helping cover the administrative costs of implementing the law.

The Middle Class Tax Relief and Job Creation Act (P.L. 112-96) included a provision to reduce the ACA's appropriations to the PPHF for each fiscal year over the period FY2013-FY2021 by a total of \$6.25 billion. Lawmakers also have used the appropriations process to rescind some or all of the ACA's funding for specific programs and amend other provisions of the law. For more details, see the answer to question 3 below.

¹⁵ For more analysis of the ACA's projected impact on federal direct spending and revenues, including details of CBO's more recent budgetary estimates, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead.

¹⁶ For a summary of all the ACA's mandatory appropriations, and the status of obligation of those funds, see CRS Report R41301, *Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (ACA)*, by C. Stephen Redhead.

Discretionary Spending

Besides its effect on direct (i.e., mandatory) spending, implementation of the ACA is likely to affect discretionary spending, which is controlled through the annual appropriations process. First, the ACA created numerous *new* discretionary grant programs and provided for each an authorization of appropriations. To date, however, few of these programs have received discretionary funding.¹⁷ Second, the ACA reauthorized funding for many *existing* discretionary grant programs authorized under the PHSA; notably, the federal health workforce programs administered by the Health Resources and Services Administration (HRSA). The authorization of appropriations for many of these programs expired prior to the ACA's enactment, though they continued to receive an annual appropriation. The ACA also permanently reauthorized appropriations for the federal health centers program and for programs and services provided by the Indian Health Service (IHS). Congressional appropriators have in general continued to provide discretionary funding for these longstanding programs, though typically at funding levels below the amounts authorized by the ACA.¹⁸

In addition, there is the discretionary spending by the federal agencies responsible for implementing the ACA's reforms. The CBO projects that the two agencies largely responsible for the law's implementation—CMS and the Internal Revenue Service (IRS)—each will incur substantial costs in connection with administering and enforcing the law. While the agencies have used mandatory funds (e.g., HIRIF) to support ACA implementation, they also have requested discretionary funds for ACA-related activities in their annual budget submissions. For FY2013, CMS requested an additional \$1 billion for ACA implementation, and the IRS requested an additional \$360 million to administer and enforce the ACA's tax-related provisions. The Full-Year Continuing Appropriations Act, 2013 (P.L. 113-6, Division F) did not provide any of these requested funds for ACA implementation.¹⁹ The Administration's FY2014 budget request included \$1.4 billion in new funds for CMS for ongoing ACA implementation, plus an additional \$440 million for the IRS for its ACA-related activities.

(3) To date, what changes to the ACA have been enacted into law?

Since the ACA's enactment in March 2010, Congress has debated implementation of the law on numerous occasions and considered multiple bills to repeal or otherwise amend the law. Most of this legislative activity has been led by lawmakers opposed to specific provisions in the ACA, or to the entire law. The legislation includes stand-alone bills and provisions in broader, often unrelated measures that would (1) repeal the law in its entirety and, in some instances, replace it with new law; (2) repeal, or by amendment restrict or otherwise limit, specific provisions in the law; (3) eliminate mandatory appropriations provided by the ACA and rescind all unobligated funds;²⁰ (4) replace ACA mandatory appropriations with authorizations of appropriations, and

¹⁷ While most of the new discretionary grant programs authorized by ACA have not received any discretionary funding, several of these programs have been supported with mandatory funds from the PPHF.

¹⁸ For more details on all the authorizations (and reauthorizations) of discretionary funding in ACA, including the FY2011-FY2013 funding levels for programs that received an appropriation, see CRS Report R41390, *Discretionary Spending in the Patient Protection and Affordable Care Act (ACA)*, coordinated by C. Stephen Redhead.

¹⁹ For more discussion on federal spending to administer and enforce ACA, see CRS Report R42051, *Budget Control Act: Potential Impact of Sequestration on Health Reform Spending*, by C. Stephen Redhead, pp. 19-21.

²⁰ Budget authority is generally made available for obligation during a specified time period, typically the upcoming fiscal year. Once budget authority reaches the end of that time period, it "expires," meaning that it is no longer available for obligation. A rescission is a provision of law that cancels budget authority prior to when it would otherwise expire, making it unavailable for future obligation. For further explanations of these terms, see GAO, A

rescind all unobligated funds; and (5) block or otherwise delay ACA implementation. A few bills with sufficiently broad and bipartisan support have been approved in both the House and the Senate and signed into law. **Table A-1** in **Appendix A** summarizes, by Congress, the authorizing legislation enacted to date that amends the ACA.

In addition, lawmakers have used the annual appropriations process to try to modify the ACA. Numerous ACA-related provisions were added to the appropriations bills considered, and in some instances reported, by the House Appropriations Committee during the past three fiscal years (i.e., FY2011-FY2013). These provisions included language prohibiting the use of discretionary funds provided in the bill to implement specific ACA provisions or the entire law, as well as broader language to repeal, restrict, or rescind direct spending for, specific ACA provisions. While none of the discretionary funding prohibitions survived, a few of the broader provisions affecting direct spending were incorporated into the final versions of the appropriations bills that were signed into law. **Table A-2** in **Appendix A** summarizes the ACA-related provisions in enacted annual appropriations acts for FY2011-FY2013.

ACA and the Annual Appropriations Process

Congress uses the annual appropriations process to fund the routine activities of most federal agencies. In addition to providing budget authority, appropriations acts may also contain provisions that seek to amend or repeal existing law, or enact new provisions of law. In some cases, these provisions affect the purposes for which appropriations are being provided, while in others, such provisions are unrelated to those purposes. If enacted into law, the legal effect of these provisions is no less valid simply because they originated in an appropriations vehicle, although there will be a rebuttable presumption that such provisions are of a temporary duration. Before these provisions are enacted, there may be procedural obstacles to including “legislative language” in an appropriations act under both House and Senate rules. These legal and procedural considerations are discussed in more detail below.

(4) Can an enacted appropriations law make substantive changes to prior laws?

An appropriations act that is passed by the Senate and House of Representatives and signed by the President, or enacted over his veto, may amend or repeal prior legislation in the same way as any other act of Congress.²¹ This can include amending or repealing prior statutes that authorize particular programs or activities, as well as prior laws that provide mandatory appropriations. In all of these cases, a primary legal concern will be whether the text of the provision is sufficiently clear to evidence Congress’s intent to amend or repeal a prior statute. In the easiest cases, the amendment or repeal will be explicit, making Congress’s intent plain. However, it is also possible for an appropriations act to implicitly amend or repeal a prior statute. Such “repeal by

Glossary of Terms Used in the Federal Budget Process, GAO-05-734SP, September 2005, pp. 85-86, available at <http://www.gao.gov>.

²¹ “Congress can and does ‘legislate’ in appropriation acts. ... It may well be that the device is ‘unusual and frowned upon.’ ... It also may well be that the appropriation act will be narrowly construed when it is in apparent conflict with authorizing legislation. ... Nevertheless, appropriation acts are, like any other statute, passed by both Houses of Congress and either signed by the President or enacted over a presidential veto. As such, and subject of course to constitutional strictures, they are ‘just as effective a way to legislate as are ordinary bills relating to a particular subject.’ *Friends of the Earth*, 485 F.2d at 9; *Envirocare of Utah Inc. v. United States*, 44 Fed. Cl. 474, 482 (1999).” GAO, 1, *Principles of Federal Appropriations Law*, 2-45 (Jan. 2004). (internal citations omitted).

implication” is generally disfavored, and courts will construe statutes to avoid this result whenever reasonably possible.²² The doctrine disfavoring repeal by implication “applies with even greater force when the claimed repeal rests solely on an Appropriations Act,” since it is presumed that appropriations laws do not normally change substantive law.²³ Nevertheless, Congress can repeal substantive law through appropriations measures if the intent to do so is clearly expressed.²⁴

(5) Does a funding restriction on enforcement of a particular law suspend that law?

An appropriations law may include a proviso restricting the use of funds provided in that act, or any other appropriations act, from being used to enforce a particular provision of law. In light of Congress’s constitutional power over the purse,²⁵ the Supreme Court has recognized that “Congress may always circumscribe agency discretion to allocate resources by putting restrictions in the operative statutes.”²⁶ Where Congress has done so, “an agency is not free simply to disregard statutory responsibilities.”²⁷

However, some provisions of the ACA may not rely exclusively upon the federal government, or the use of federal funds, to operate. For example, the ACA imposed numerous new restrictions on health insurers, such as prohibiting preexisting condition exclusions and requiring coverage of certain preventive services without cost-sharing. While the federal government has a role in enforcing such provisions, these requirements may also be enforced by state entities or via civil lawsuits brought by participants or beneficiaries of a group health plan.²⁸ Because these enforcement actions may not involve the expenditure of federal funds, it is possible that provisions such as these would not be completely impaired by a simple funding restriction, unless that funding restriction also had the effect of explicitly or implicitly repealing the underlying law as described above.

(6) How long is a provision in an appropriations act effective?

A second question that frequently arises in the context of funding limitations is whether the limitation is of a temporary or permanent nature. As annual appropriations acts (including CRs) are made for a particular fiscal year or other fixed time period, it is generally presumed that everything contained in the act is effective only for the fiscal year or time period covered. This presumption can be defeated if the provision uses “words of futurity” or if the provision is of a general character bearing no relation to the object of the appropriation.²⁹ Common “words of futurity” include “hereafter,” “henceforth,” or “after the date of approval of this Act.”³⁰

²² GAO, 1, *Principles of Federal Appropriations Law*, 2-43 (Jan. 2004) (citing *TVA v. Hill*, 437 U.S. 153 (1974)).

²³ *TVA v. Hill*, 437 U.S. 153, 190 (1978).

²⁴ *U.S. v. Will*, 449 U.S. 200, 222 (1980).

²⁵ U.S. CONST. art. I, § 9, cl. 7 (“No Money shall be drawn from the Treasury but in Consequence of Appropriations made by Law”).

²⁶ *Lincoln v. Vigil*, 508 U.S. 182, 192-193 (1993).

²⁷ *Id.*

²⁸ 42 U.S.C. § 300gg-22; 29 U.S.C. § 1132.

²⁹ GAO, 1 *Principles of Federal Appropriations Law 3d*, GAO-04-261SP, at 2-34 (Jan. 2004).

³⁰ *Id.* at 2-35.

Additionally, if the provision bears no direct relationship to the appropriations act in which it appears, this is an indication of permanence. For example, a provision prohibiting the retroactive application of an existing tax credit made no mention of the use of funds, and was found sufficiently unrelated to the rest of a supplemental appropriations act to support a conclusion of permanence.³¹ There does not appear to be a bright line rule; instead, the further the relationship, the greater the inference of permanence will be. Additionally the “determination under rules of the Senate that a proviso is germane to the subject matter of the appropriation bill will negate an argument that the proviso is sufficiently unrelated as to suggest permanence.”³²

(7) How might House and Senate procedural rules specific to considering appropriations measures affect the inclusion of language that repeals, defunds, or otherwise amends the ACA?³³

The primary procedural restrictions in the House and Senate that are specific to the content of appropriations measures, and amendments thereto, are found in House Rule XXI and Senate Rule XVI. These rules restrict the inclusion of “legislative language” in appropriations measures, a restriction that is based on whether the language has the effect of changing existing law.³⁴ While the language of the House and Senate rules and their associated precedents have some points of difference,³⁵ both chambers have generally considered legislative language to include any provision in an appropriations measure that would repeal or amend provisions in another act.³⁶ Consequently, because mandatory funding mechanisms are based on the requirements of other enacted laws, an appropriations provision that defunds the mandatory spending in ACA through repealing, amending, or superseding that law would likely be considered by the House and Senate to be legislative.³⁷

While both House and Senate rules restrict the inclusion of legislative language in general appropriations bills, these restrictions are applicable in different circumstances. Clauses 2(b) and (c) of House Rule XXI prohibit the inclusion of legislative language in general appropriations bills and amendments thereto;³⁸ clause 5 of House Rule XXII also prohibits legislative language

³¹ *Id.* at 2-38 (citing B-214508, Feb. 1, 1984, available at <http://www.gao.gov/products/B-214058>).

³² Such determinations would occur as part of the legislative history of the appropriations act. *Id.*

³³ This section draws, in part, on information contained in CRS Report R41634, *Limitations in Appropriations Measures: An Overview of Procedural Issues*, by Jessica Tollestrup. For further information on these issues, see pp. 1-6.

³⁴ House Rule XXI, clauses 2(b) and (c); Senate Rule XVI, paragraphs 2 and 4. Under the precedents associated with these rules, “legislative language” is any provision that would add to or alter existing law, either explicitly or implicitly.

³⁵ For example, Senate Rule XVI, paragraphs 2 and 4 explicitly excludes as legislative any language that includes a funding prohibition that takes effect upon a contingency. In the House, the language of the rule does not explicitly address contingencies, but associated precedents include many instances where contingent funding prohibitions are considered to be legislative. For further information, see Rules of the House of Representatives, in *House Manual, One Hundred Thirteenth Congress*, H.Doc. 112-161, 112th Cong., 2nd sess., [compiled by] Thomas J. Wickham, Parliamentarian (Washington: GPO, 2013), [Hereafter, *House Manual*] § 1055.

³⁶ *House Manual*, § 1056; Floyd M. Riddick and Alan S. Frumin, *Riddick’s Senate Procedure: Precedents and Practices*, 101st Cong., 2nd sess., S. Doc. 101-28 (Washington: GPO, 1992), [Hereafter *Riddick’s Senate Procedure*], pp. 190-191.

³⁷ The House and Senate parliamentarians are the advisers to the presiding officers on what constitutes legislative language within the appropriations context. This report should not be considered a substitute for consultation with the parliamentarian and his associates on specific procedural problems and options.

³⁸ In the House, this prohibition also includes motions to recommit general appropriations measures with instructions

in conference reports for general appropriations bills. In contrast, while paragraphs 2 and 4 of Senate Rule XVI generally prohibit the inclusion of legislative language in committee or floor amendments to general appropriations bills,³⁹ the rule also includes exceptions that would allow legislative language under certain circumstances. Specifically, legislative amendments are allowed when they are determined to be germane to legislative language passed by the House and already contained in the appropriations bill. If a point of order is raised against an amendment based on it including legislative language, the proponent may counter by raising a “defense of germaneness.” That is, the proponent may ask for a decision of the Senate to allow the amendment notwithstanding the legislative language because it is germane to legislative language already in the bill. If a germaneness defense is raised for an amendment, the presiding officer makes an initial “threshold” determination as to whether there exists “any House language which is arguabl[y] legislative to which the amendment at issue conceivably could be germane.”⁴⁰ If the bill is determined to contain such language, the question is put to the Senate for an immediate vote, so that if a majority of Senators affirms that the amendment is germane, the point of order falls and the amendment containing legislation is eligible for floor consideration. There is one significant modification to the procedures just described if the Senate amendment is to a House-passed bill containing continuing appropriations or to a continuing resolution. Under a Senate precedent, if the defense of germaneness is raised for an amendment, the presiding officer submits the question directly to the Senate without first making any threshold determination.⁴¹

In addition to prohibiting legislative language in different circumstances, the precedents associated with House Rule XXI and Senate Rule XVI also use different definitions as to what constitutes a “general appropriations bill.” In the House, general appropriations bills are the annual appropriations acts (or any combination thereof) and any supplemental appropriations acts that cover more than one agency. Continuing resolutions are not considered to be general appropriations bills.⁴² In the Senate, “general appropriations bills” are the annual appropriations measures (or any combination thereof) and any supplemental or continuing appropriations measures that cover more than one agency or purpose.⁴³ As a consequence of these definitions, the House may consider and pass a CR containing legislative language, and the Senate may take up a House-passed CR and consider germane amendments, without violating the respective rules of either chamber.

On this and other matters, the rules of the House and Senate are not self-enforcing. A Member must raise a point of order during consideration of the measure or amendment to trigger the procedures described above.⁴⁴ In addition, the House may waive clauses 2(b) and (c) of Rule XXI through the adoption of a special rule, unanimous consent, or suspension of the rules.⁴⁵ The

containing legislative language (see *House Manual*, § 1044).

³⁹ In the Senate, this prohibition on legislative language in amendments includes amendments between the houses (*Riddick’s Senate Procedure*, p. 190).

⁴⁰ *Riddick’s Senate Procedure*, p. 167.

⁴¹ *Ibid.*, p. 168.

⁴² See *House Manual*, § 1044.

⁴³ *Riddick’s Senate Procedure*, p. 159.

⁴⁴ For further information, see CRS Report 98-307, *Points of Order, Rulings, and Appeals in the House of Representatives*, by Valerie Heitshusen, and CRS Report 98-306, *Points of Order, Rulings, and Appeals in the Senate*, by Valerie Heitshusen.

⁴⁵ For a discussion of these practices in the context of regular appropriations measures, see CRS Report R42933, *Regular Appropriations Bills: Terms of Initial Consideration and Amendment in the House, FY1996-FY2013*, by Jessica Tollestrup.

Senate, likewise, may waive paragraphs (2) and (4) of Rule XVI through unanimous consent or suspension of the rules.⁴⁶

Potential Impact of a Shutdown on ACA Implementation

(8) What will happen to ACA implementation during a government shutdown?

In brief, it appears that substantial ACA implementation will continue during a lapse in annual appropriations that results in a temporary government shutdown, for two reasons.

- The first reason is that some agencies in the federal government will be able to rely on sources of funding other than annual discretionary appropriations to support implementation activities. Such funding includes multiple-year and no-year discretionary funds appropriated in prior fiscal years that are still available for obligation, as well as mandatory funds.⁴⁷
- The second reason is that during a lapse in appropriations (also known as a “funding gap”),⁴⁸ agencies may continue to perform certain types of activities that fall under exceptions to the Antideficiency Act.⁴⁹ The Antideficiency Act generally prohibits continued operations in the absence of appropriations, except under certain circumstances.⁵⁰ Some of these circumstances and related exceptions to the Antideficiency Act likely would be relevant to ACA implementation, in the event of a shutdown, allowing certain operations to continue.

More information regarding these matters is addressed below.

(9) Are there alternative sources of funding to implement the ACA in the absence of appropriated funds for FY2014?

Yes. As discussed in the answer to question 2, the ACA created a Health Insurance Reform Implementation Fund (HIRIF), to which it appropriated \$1 billion in mandatory funding. Both

⁴⁶ For further information on suspension of the rules for Rule XVI, see *Riddick's Senate Procedure*, pp. 177.

⁴⁷ The term “multiple-year budget authority” refers to budget authority that remains available for obligation for a fixed period of time in excess of one fiscal year. The term “no-year budget authority” refers to budget authority that remains available for an indefinite period of time (e.g., “to remain available until expended”). See U.S. Government Accountability Office (hereinafter GAO), *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, p. 22. Mandatory funding refers to budget authority that is provided in and controlled by laws other than the annual appropriations acts.

⁴⁸ For more information about funding gaps, see CRS Report RS20348, *Federal Funding Gaps: A Brief Overview*, by Jessica Tollestrup.

⁴⁹ 31 U.S.C. § 1341. The Antideficiency Act (31 U.S.C. §§ 1341-1342, §§ 1511-1519) is discussed in CRS Report RL30795, *General Management Laws: A Compendium*, by Clinton T. Brass et al., pp. 93-97. GAO provides information on the act, at <http://www.gao.gov/legal/lawresources/antideficiencybackground.html>.

⁵⁰ For more detailed discussion of the framework under which a shutdown would take place, see CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*, coordinated by Clinton T. Brass.

CMS and the IRS have used these mandatory funds to cover the costs associated with the ACA's implementation. The Obama Administration's FY2013 budget projected that all the HIRIF funds would be obligated by the end of FY2012 and, thus, requested almost \$1.4 billion in new discretionary funding for CMS and the IRS to pay for ongoing implementation activities. Overall, CMS estimated that it would spend about \$1.5 billion on ACA implementation in FY2013, primarily to establish the federally facilitated exchanges and related information technology (i.e., data services hub) and to conduct consumer outreach and education.⁵¹

Congress, however, did not provide any new discretionary funding for ACA implementation in FY2013. In the absence of those funds, it was reported that HHS planned to use funds from the following sources:⁵²

- approximately \$235 million in unobligated HIRIF funds carried over from FY2012;⁵³
- \$454 million in mandatory funds from the PPHF;
- \$450 million in no-year funds from the nonrecurring expenses fund (NEF);⁵⁴ and
- approximately \$116 million from the Secretary's authority to transfer funds from other HHS accounts.⁵⁵

The Administration's FY2014 budget requested \$1.4 billion in new discretionary funds for CMS Program Management for ongoing ACA implementation activities, plus an additional \$400 million in discretionary funds for the IRS to administer the ACA's tax-related provisions, including the premium tax credits.⁵⁶ Both in the case of the current lapse in FY2014 discretionary appropriations and in the event that Congress does not provide any new discretionary funding for the ACA in the FY2014 appropriations acts, it appears that the agencies will continue to rely on alternative sources of funding to support ACA implementation activities. Indeed, the HHS contingency plan for operations in the absence of FY2014 appropriations states that "CMS would continue large portions of ACA activities, including coordination between Medicaid and the [exchanges]...."⁵⁷

⁵¹ John Reichard, "HHS Using Several Sources to Fund Federal Health Insurance Exchange," *CQ Roll Call*, April 10, 2013.

⁵² *Ibid.*

⁵³ HHS did not, in fact, obligate all the HIRIF funds by the end of FY2012 as was originally projected.

⁵⁴ The nonrecurring expenses fund, within the Department of the Treasury, was established by Division G, Section 223 of the Consolidated Appropriations Act, 2008 (P.L. 110-161, 121 Stat. 1844). The HHS Secretary may transfer to the fund unobligated balances of expired annual discretionary funds up to five years after the fiscal year in which those funds were available for obligation. The amounts transferred to the fund are available until expended for use by HHS for "capital acquisition necessary for operation of the Department, including facilities infrastructure and information technology infrastructure ..." Congressional appropriators must be notified at least 15 days in advance of any planned use of funds.

⁵⁵ Each year, the Labor-HHS-ED appropriations act gives the HHS Secretary authority to transfer funds between appropriations accounts. No more than 1% of the funds in any given account may be transferred, and recipient accounts may not be increased by more than 3%. Congressional appropriators must be notified at least 15 days in advance of any transfer. For more information about statutory transfer authorities, generally, see CRS Report R43098, *Transfer and Reprogramming of Appropriations: An Overview of Authorities, Limitations, and Procedures*, by Michelle D. Christensen.

⁵⁶ U.S. Department of Health and Human Services, *Budget in Brief, FY2014*, at <http://www.hhs.gov/budget/fy2014/fy-2014-budget-in-brief.pdf>; U.S. Department of the Treasury, Internal Revenue Service, *Budget in Brief, FY2014*, at <http://www.irs.gov/PUP/newsroom/FY%202014%20Budget%20in%20Brief.pdf>.

⁵⁷ Department of Health and Human Services, *Fiscal Year 2014: Contingency Staffing Plan for Operations in the Absence of Enacted Annual Appropriations*, http://www.hhs.gov/budget/fy2014/fy2014contingency_staffing_plan-

Additionally, programs or activities that are supported by permanent appropriations provided in the ACA would continue to have at least some funding available in the event of a funding lapse. For example, the ACA amended the Internal Revenue Code (IRC) authorizing refundable tax credits to subsidize the health insurance premiums for certain low-income taxpayers who enroll in a health plan offered through a health insurance exchange established by a state.⁵⁸ Like many other tax credits, the monies used to fund such provisions are permanently appropriated outside of the annual appropriations process.⁵⁹ Therefore, the funds for such credits would continue to be available via this permanent appropriation during a government shutdown caused by a lapse in annual appropriations.

(10) In the absence of FY2014 appropriated funding, will some ACA-related activities continue during a government shutdown? If so, how will these decisions be made?

Various ACA-related activities will continue in the absence of annual appropriations. Some background information helps explain why this is the case, but it is first necessary to identify caveats when addressing this subject.

In the context of a prospective or actual lapse in appropriations and government shutdown, several presidential administrations have interpreted the nature and scope of restrictions on government activities during a shutdown and any related exceptions. These interpretations came by way of legal opinions and guidance documents issued by former U.S. Attorney General Benjamin R. Civiletti, the Department of Justice's (DOJ's) Office of Legal Counsel, and OMB. In these documents, the administrations identified specific exceptions that govern federal agency decisions regarding which operations may continue during a government shutdown under certain circumstances. These exceptions arguably have been read broadly, resulting in a situation where executive agencies may exercise some discretion. It is important to note that *past* views and practice in the executive branch do not necessarily constrain or guide what may happen in the current, or any future, funding lapse and shutdown. Consequently, CRS is not able to predict what will happen for specific programs, agencies, or activities, in a shutdown. Nevertheless, analysis of the operative legal framework, past events, and current agency-specific circumstances may help illuminate the contours of what *might* happen in such a situation. In addition, agency determinations of what activities will continue or not continue may change over the course of a shutdown, particularly if it persists for an extended period. Consequently, agency shutdown plans may be updated over time or be overtaken by events.

The Constitution, statutory provisions, court opinions, and DOJ opinions provide the legal framework for how funding gaps and shutdowns have occurred in recent decades.⁶⁰ Article I, Section 9 of the Constitution states that “No Money shall be drawn from the Treasury, but in

rev2.pdf. See page 2. The plan further states that “[s]everal HHS agencies have substantial mandatory, carryover, or user fee funds which are not affected by a hiatus in annual appropriations, with CMS having the most mandatory funds, including ... ACA Mandatory Program Management ... [and] the ACA Implementation Fund....” See page 6.

⁵⁸ I.R.C. § 36B. Treasury regulations implementing this provision have stated that such credits will also be available in those exchanges established by HHS on behalf of a state. Treas. Reg. § 1.36b-1(k). Some have questioned whether the statute permits these credits with respect to coverage in federally facilitated exchanges. A full discussion of that issue is beyond the scope of this report.

⁵⁹ 31 U.S.C. § 1324.

⁶⁰ For more in-depth discussion, see CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*, coordinated by Clinton T. Brass.

Consequence of Appropriations made by Law.” Federal employees and contractors cannot be paid, for example, if appropriations have not been enacted. Nevertheless, it would appear possible under the Constitution for the government to make contracts or other obligations even if it lacked funds to pay for these commitments.⁶¹ The Antideficiency Act generally prevents this, however. The act prohibits federal officials from obligating funds before an appropriations measure has been enacted, except as authorized by law.⁶² The act also prohibits acceptance of voluntary services and employment of personal services exceeding what has been authorized by law.⁶³ Therefore, the Antideficiency Act generally prohibits agencies from continued operation in the absence of appropriations.

Two opinions in 1980 and 1981 from then-U.S. Attorney General Benjamin R. Civiletti and another DOJ opinion from DOJ’s Office of Legal Counsel in 1995, generally have guided actions in the executive branch in recent decades.⁶⁴ The Attorney General’s opinions stated that, with some exceptions, the head of an agency could avoid violating the Antideficiency Act only by suspending the agency’s operations until the enactment of an appropriation. In the absence of appropriations, exceptions would be allowed only when there is “some reasonable and articulable connection between the function to be performed and the safety of human life or the protection of property.” Apart from this broad category of “human life and property” exceptions to the Antideficiency Act, the Civiletti opinions identified another broad category of exceptions: those that are “authorized by law.” The Government Accountability Office (GAO) later summarized the 1981 Civiletti opinion as identifying four sub-types of “authorized by law” exceptions:⁶⁵

- Activities funded with appropriations of budget authority that do not expire at the end of one fiscal year, such as multiple-year and no-year appropriations (that is, when these multiple-year and no-year appropriations still have budget authority available for obligation at the time of a funding gap).⁶⁶

⁶¹ For discussion, see prepared statement of Walter Dellinger, Assistant Attorney General, in U.S. Congress, Senate Committee on the Budget and House Committee on the Budget, *Effects of Potential Government Shutdown*, hearing, 104th Cong., 1st sess., September 19, 1995, S.Hrg. 104-175 (Washington: GPO, 1995), p. 18. Some commentators, however, have expressed a contrary view. See Jim Schweiter and Herb Fenster, *Government Contract Funding under Continuing Resolutions*, 95 Fed. Cont. Rep. 180, note 17 (February 15, 2011).

⁶² 31 U.S.C. § 1341. The Antideficiency Act (31 U.S.C. §§ 1341-1342, §§ 1511-1519) is discussed in CRS Report RL30795, *General Management Laws: A Compendium*, by Clinton T. Brass et al., pp. 93-97. GAO provides information on the act, at <http://www.gao.gov/legal/lawresources/antideficiencybackground.html>.

⁶³ 31 U.S.C. § 1342; see also § 1515.

⁶⁴ For discussion and citations, see CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*, coordinated by Clinton T. Brass. The two Civiletti opinions are included in a GAO report as Appendices IV and VIII. See GAO (then the General Accounting Office), *Funding Gaps Jeopardize Federal Government Operations*, PAD-81-31, March 3, 1981, at <http://www.gao.gov/assets/140/132616.pdf>.

⁶⁵ The bulleted text here draws, in part, from GAO, *Principles of Federal Appropriations Law*, 3rd ed., vol. II, GAO-06-382SP, February 2006, chapter 6, pp. 6-149 – 6-150. GAO also noted that the courts have added to the list of exceptions to the Antideficiency Act in certain circumstances (*ibid.*, p. 6-152). The 1980 Civiletti opinion also included in the “authorized by law” exception an inference that federal officers may exercise authority to incur minimal obligations necessary to closing their agencies in an orderly way.

⁶⁶ As discussed in question 9, activities that have funds available to them, notwithstanding the lack of new discretionary appropriations for that fiscal year, may continue to use those funds. In addition, agencies that receive most or all of their budget authority for their day-to-day operations through means that are not dependent on appropriations acts, such as the U.S. Postal Service and the Bureau of Consumer Financial Protection in the Federal Reserve System, would fall under this exception.

- Activities authorized by statutes that expressly permit obligations in advance of appropriations, such as contract authority.⁶⁷
- Activities “authorized by necessary implication from the specific terms of duties that have been imposed on, or of authorities that have been invested in, the agency.” The Civiletti opinion illustrated this concept by citing the situation when benefit payments under an entitlement program are funded from other-than-one-year appropriations (i.e., where benefit payments are not subject to a funding gap, because they are authorized by permanent entitlement authority),⁶⁸ but the salaries of personnel who administer the program are funded by one-year appropriations (i.e., the salaries are subject to a funding gap). In this situation, the Attorney General offered the view that continued availability of money for benefit payments would necessarily imply that continued administration of the program is authorized by law at some level and therefore excepted from the Antideficiency Act.⁶⁹
- Obligations “necessarily incident to presidential initiatives undertaken within his constitutional powers,” such as the power to grant pardons and reprieves.

In 1990, in response to the 1981 Civiletti opinion, Congress amended 31 U.S.C. §1342 to clarify that “the term ‘emergencies involving the safety of human life or the protection of property’ does not include ongoing, regular functions of government the suspension of which would not imminently threaten the safety of human life or the protection of property.”⁷⁰ DOJ’s Office of Legal Counsel (OLC) issued a memorandum in 1995 that interpreted the effect of the amendment (hereinafter, “1995 OLC opinion”).⁷¹ The 1995 OLC opinion noted that one aspect of the 1981 Civiletti opinion’s description of emergency governmental functions should be modified in light of the amendment, but that the 1981 opinion otherwise “continues to be a sound analysis of the legal authorities respecting government operations” during a funding gap.⁷² More recently, OMB summarized its interpretation of exceptions to the Antideficiency Act in memoranda that were issued to agencies in April and December 2011 (regarding FY2011 and FY2012 annual appropriations, respectively), and September 2013 (regarding FY2014 annual appropriations).⁷³

⁶⁷ For explanation of contract authority, see GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP, September 2005, p. 21.

⁶⁸ In such a case, budget authority is available to make payments as a result of previously enacted legislation and is available without further legislative action. “Entitlement authority” refers to authority to make payments (including loans and grants) for which budget authority is not provided in advance by appropriations acts to any person or government if, under the provisions of the law containing such authority, the federal government is legally required to make the payments to persons or governments that meet the requirements established by law. See *ibid.*, pp. 22-23 and 47.

⁶⁹ For an example of this exception in the context of two shutdowns during FY1996, see the section titled “Effects on Mandatory Spending Programs,” in CRS Report RL34680, *Shutdown of the Federal Government: Causes, Processes, and Effects*, coordinated by Clinton T. Brass.

⁷⁰ *Ibid.*, p. 6-151, citing P.L. 101-508, 104 Stat. 1388, at 1388-621 (now codified at 31 U.S.C. §1342).

⁷¹ U.S. Department of Justice, Office of Legal Counsel, *Government Operations in the Event of a Lapse in Appropriations*, memorandum from Walter Dellinger, Assistant Attorney General, for Alice Rivlin, Director, Office of Management and Budget, August 16, 1995, reprinted in U.S. Congress, Senate Committee on the Budget and House Committee on the Budget, *Effects of Potential Government Shutdown*, hearing, 104th Cong., 1st sess., September 19, 1995, S.Hrg. 104-175 (Washington: GPO, 1995), pp. 77-85.

⁷² *Ibid.*, p. 78. In light of the intervening amendments, the 1995 OLC opinion required the safety of human life or the protection of property to be compromised “in some significant degree” in order for a function to be considered excepted.

⁷³ OMB Memorandum M-11-13, *Planning for Agency Operations During a Lapse in Government Funding*, April 7,

Pursuant to instructions from OMB, most executive branch agencies posted shutdown plans on OMB's website in April and December 2011, in anticipation of potential shutdowns related to FY2011 and FY2012 funding.⁷⁴ With regard to the plans, most agencies created both a Web page describing shutdown procedures as well as distributable PDF documents. The resources covered many topics, including discussion of excepted and non-excepted employees. Additional topics included shutdown precedents, guidelines, furlough policies, and frequently asked questions. Documents also addressed availability of government services, unemployment compensation for federal employees, union concerns, and information about past shutdowns. On September 17, 2013, OMB directed agencies to update these plans and prepare for their potential release, in the event that there would be a lapse in FY2014 annual appropriations.⁷⁵

OMB has now posted the updated shutdown plans (also called contingency plans) on its website.⁷⁶ These plans may be modified and re-posted. Some press outlets have reported on the contents of these plans and their potential implications for agency activities.⁷⁷ As noted in the answer to the question 9, HHS has substantial mandatory and other funds with which to continue ACA implementation. In addition, other factors likely will contribute to continued ACA implementation, including

- ACA-related activities being related to mandatory spending programs, under the “necessary implication” exception to the Antideficiency Act; and
- ACA-related activities being related to safety of human life and protection of property and the corresponding exception to the Antideficiency Act.

It should also be noted that a lapse in funding does not automatically result in the suspension of applicable laws, including the filing and payment deadlines applicable to taxes created by the ACA. While some tax enforcement and collection activities may be unavailable during a government shutdown, those authorities would resume if funding is subsequently provided for the IRS, and any outstanding tax liabilities accrued during that time period may be subject to enforcement and collection at that time.

Additionally, as discussed above in the context of funding restrictions, some provisions of the ACA may not rely exclusively upon the federal government, or the use of federal funds, to operate. For example, the ACA imposed numerous new restrictions on health insurers, such as prohibiting preexisting condition exclusions and requiring coverage of certain preventive services without cost-sharing. While the federal government has a role in enforcing such provisions, these requirements may also be enforced by state entities or via civil lawsuits brought by participants or beneficiaries of a group health plan.⁷⁸ Because these enforcement actions may not involve the expenditure of federal funds, it is possible that provisions such as these would not be completely impaired by a government shutdown. Furthermore, because a funding lapse is the result of

2011, pp. 4-6; OMB Memorandum M-12-03, *Planning for Agency Operations During a Lapse in Government Funding*, December 15, 2011, Attachment 1 (first three pages of non-paginated attachment); and OMB Memorandum M-13-22, *Planning for Agency Operations During a Potential Lapse in Appropriations*, September 17, 2013, pp. 3-5.

⁷⁴ The plans were posted online, at OMB, “Agency Contingency Plans,” at <http://www.whitehouse.gov/omb/contingency-plans>.

⁷⁵ OMB Memorandum M-13-22, *Planning for Agency Operations During a Potential Lapse in Appropriations*, September 17, 2013, Attachment 1.

⁷⁶ See <http://www.whitehouse.gov/omb/contingency-plans>.

⁷⁷ See, for example, at WashingtonPost.com, “Impact of a Government Shutdown,” <http://www.washingtonpost.com/wp-srv/special/politics/2013-shutdown-federal-department-impact/>; and “Government Shutdown: What’s Open, What’s Closed,” <http://www.washingtonpost.com/wp-srv/special/politics/whats-open-whats-closed/>.

⁷⁸ 42 U.S.C. § 300gg-22; 29 U.S.C. § 1132.

legislative inaction, a government shutdown could not have the effect of either explicitly or implicitly repealing the underlying law as described above.

Appendix A. Laws that Repeal or Amend Provisions of the Affordable Care Act

Table A-1 summarizes the authorizing legislation enacted to date to amend the ACA. Each table entry includes the public law number and date of enactment, the original bill number and sponsor, and a brief description and explanation of the change(s) made to the ACA. The laws are listed in chronological order beginning with the first measure signed into law following the enactment of ACA and the accompanying package of amendments in HCERA.⁷⁹ In compiling the table, CRS made decisions about which laws—or specific provisions in a particular law—to include, and which ones to leave out. Generally, CRS has included only those laws that amend, or make changes that relate to, *new* programs and activities established under the ACA. CRS has excluded laws that amend or extend *established* programs and activities that were subject to prior amendment by the ACA. For example, the ACA extended multiple existing Medicare and Medicaid program payments and activities that have since been further extended and/or modified by more recently enacted laws. None of these laws are included in **Table A-1**.

Table A-2 summarizes the ACA-related provisions that have been included in enacted annual appropriations acts for the past three fiscal years (i.e., FY2011-FY2013).

The following laws are referred to in the tables by their acronym:

- Health Care and Education Reconciliation Act (HCERA; P.L. 111-152);
- Internal Revenue Code (IRC);
- Medicare Improvements for Patients and Providers Act (MIPPA; P.L. 110-275);
and
- Social Security Act (SSA).

⁷⁹ See footnote 1.

Table A-1. Enacted Authorizing Legislation That Amends the ACA

Public Law and Date of Enactment	Bill (Sponsor)	Summary of Provisions
111th Congress		
P.L. 111-159 Apr. 26, 2010	H.R. 4887 (Skelton)	TRICARE Affirmation Act. Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided under TRICARE, TRICARE for Life, and the Nonappropriated Fund Health Benefits program constitutes minimal essential health care coverage as required by ACA. [Beginning in 2014, ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]
P.L. 111-173 May 27, 2010	H.R. 5014 (Filner)	[No title.] Amended IRC Section 5000A(f)(1)(A), as added by ACA Section 5101(b), to clarify that health care provided by the Department of Veterans Affairs constitutes minimal essential health care coverage as required by ACA. [Beginning in 2014, ACA requires most U.S. citizens and legal residents to have minimal essential health care coverage or pay a penalty.]
P.L. 111-226 Aug. 10, 2010	H.R. 1586 (Rangel)	FAA Air Transportation Modernization and Safety Improvement Act. Among its many provisions, P.L. 111-226 amended SSA Section 1927(k)(1)(B)(i)(IV) (as added by ACA Section 2503(a)(2)(B), as amended by HCERA Section 1101(c)) by modifying the definition of average manufacturer price (AMP) to include inhalation, infusion, implanted, or injectable drugs that are not generally dispensed through a retail community pharmacy.
P.L. 111-309 Dec. 15, 2010	H.R. 4994 (Lewis)	Medicare and Medicaid Extenders Act of 2010. To help offset the costs of the Medicare and Medicaid program extensions and the postponement of cuts in Medicare physician payments, P.L. 111-309 amended IRC Section 36B (as added by ACA Section 1401(a)) to modify the amount of excess premium tax credits that individuals would have to repay. The law created a sliding scale for such repayments based on household income. [Under ACA, the amount received in premium credits is based on income as reported on tax returns. These amounts are reconciled the following year, which could result in an overpayment of credits if income increases. ACA placed limits on the amount of any premium credit overpayment that had to be repaid to the government.]
P.L. 111-312 Dec. 17, 2010	H.R. 4853 (Oberstar)	Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010. Amended ACA Section 10909 to extend the nonrefundable adoption tax credit through tax year 2012. The adoption tax credit helps offset the cost of qualified adoption expenses. [Subsequently, P.L. 112-240 made the nonrefundable adoption tax credit permanent.]
P.L. 111-383 Jan. 7, 2011	H.R. 6523 (Skelton)	Ike Skelton National Defense Authorization Act for Fiscal Year 2011. Extended TRICARE coverage to dependent adult children up to age 26, to conform with the private health insurance requirements under ACA.
112th Congress		
P.L. 112-9 Apr. 14, 2011	H.R. 4 (Lungren)	Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011. Amended IRC Section 6041, as amended by ACA Section 9006, to repeal the requirement that businesses file an information report (IRS Form 1099) whenever they pay a vendor more than \$600 for goods in a single year. To pay for the 1099 repeal, P.L. 112-9 further amended IRC Section 36B, as added by ACA Section 1401(a), by modifying the amount of excess premium tax credits that individuals would have to repay based on household income (see entry for P.L. 111-309, above).

Public Law and Date of Enactment	Bill (Sponsor)	Summary of Provisions
P.L. 112-56 Nov. 21, 2011	H.R. 674 (Herger)	3% Withholding Repeal and Job Creation Act. Among its many provisions, P.L. 112-56 amended IRC Section 36B, as added by ACA section 1401(a) (as amended), by modifying the calculation of Modified Adjusted Gross Income (MAGI) to include Social Security benefits. MAGI will be used to determine eligibility for health insurance exchange subsidies and Medicaid, beginning in 2014.
P.L. 112-96 Feb. 22, 2012	H.R. 3630 (Camp)	Middle Class Tax Relief and Job Creation Act of 2012. Among its many provisions, P.L. 112-96: <ul style="list-style-type: none"> Amended ACA Section 4002 to reduce the Prevention and Public Health Fund (PPHF) annual appropriations over the period FY2013-FY2021 by a total of \$6.25 billion to help offset the cost of extending the payroll tax cut. Amended SSA Section 1923(f) to extend by one year the disproportionate share hospital (DSH) allotment reduction imposed by ACA Section 3203. Amended SSA Section 1905(aa), as added by ACA Section 2006, to make a technical correction to the formula to phase down the Medicaid disaster-recovery Federal Medical Assistance Percentage (FMAP) adjustment as originally intended. [The purpose of the adjustment was to help Louisiana avoid a significant reduction in its federal Medicaid match (i.e., FMAP) in the aftermath of Hurricane Katrina. As written in ACA Section 2006, the formula for the disaster-recovery FMAP adjustment unintentionally caused the FMAP adjustment to increase, rather than phase down, each year the state qualifies for the adjustment.]
P.L. 112-141 July 6, 2012	H.R. 4348 (Mica)	Moving Ahead for Progress in the 21st Century Act, or “MAP-21”. Among its many provisions, P.L. 112-141 further modified the Medicaid disaster-recovery FMAP adjustment (see entry for P.L. 112-96, above) by changing the adjustment factor and the effective date.
P.L. 112-240 Jan. 2, 2013	H.R. 8 (Camp)	American Taxpayer Relief Act of 2012. Among its many provisions, P.L. 112-240: <ul style="list-style-type: none"> Amended MIPAA Section 119 to provide a total of \$25 million for FY2013 for the four outreach and assistance programs, which ACA Section 3306 funded through FY2012. Amended SSA Section 501(c)(1)(A) to provide \$5 million for FY2013 for the family-to-family information centers, which ACA Section 5507(b) funded through FY2012. Transferred 10% of the remaining unobligated Consumer Operated and Oriented Plan (CO-OP) program funds to a new CO-OP contingency fund (to provide assistance and oversight to CO-OP loan recipients) and rescinded the other 90% of those funds (see entries for P.L. 112-10 and P.L. 112-74, which predate this act, in Table 2 below).^a Repealed ACA Title VIII, the Community Living Assistance Services and Supports (CLASS) Act. Repealed ACA’s appropriations for the National Clearinghouse for Long-Term Care Information and rescinded all unobligated funds.

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

- a. P.L. 112-10 and P.L. 112-74 rescinded a total of \$2.6 billion of ACA’s original \$6 billion appropriation for the CO-OP program (see **Table 2**). At the time P.L. 112-240 was enacted, according to HHS budget documents, the CO-OP program had an unobligated balance of \$2.532 billion. P.L. 112-240 rescinded 90% of that amount (i.e., \$2.279 billion), and remaining funds (i.e., \$253 million) were transferred to the contingency fund. In all, Congress has rescinded \$4.879 billion of the \$6 billion CO-OP program appropriation.

Table A-2. ACA-Related Provisions in Annual Appropriations Acts, FY2011-FY2013

Public Law and Date of Enactment	Bill (Sponsor)	Summary of Provisions
P.L. 112-10 Apr. 15, 2011	H.R. 1473 (Rogers)	<p>Department of Defense and Full-Year Continuing Appropriations Act, 2011. Division B, Title VIII of P.L. 112-10, which provided full-year continuing FY2011 appropriations for Labor-HHS-Education, included the following ACA-related provisions:</p> <ul style="list-style-type: none"> • Permanently canceled \$2.2 billion of the \$6 billion appropriation for the Consumer Operated and Oriented Plan (CO-OP) program, which was established and funded by ACA Section 1322. • Repealed the free choice voucher program, established by ACA Section 10108, which would have required certain employers to provide vouchers to qualified employees for purchasing coverage through a health insurance exchange. • Prohibited transfers from the Public Health and Social Services Emergency Fund to support the U.S. Public Health Sciences Track, pursuant to ACA Section 5315. • Removed the maintenance of effort requirement for use of monies in the Community Health Center Fund (CHCF), which was established and funded by ACA Section 10503 (as amended by HCERA Section 2303). • Mandated a Government Accountability Office (GAO) study of the costs and processes of ACA implementation, and a Medicare actuarial analysis of the impact of ACA's private insurance reforms on employer-sponsored health insurance premiums.
P.L. 112-74 Dec. 23, 2011	H.R. 2055 (Culberson)	<p>Consolidated Appropriations Act, 2012. Division F of P.L. 112-74, which provided regular FY2012 appropriations for Labor-HHS-Education, included the following ACA-related provisions:</p> <ul style="list-style-type: none"> • Rescinded \$400 million of the remaining \$3.8 billion for the CO-OP program; see P.L. 112-10, above. • Rescinded \$10 million of the \$15 million FY2012 appropriation for the Independent Payment Advisory Board (IPAB), which was authorized and funded by ACA Section 3403. • Instructed the Secretary of Health and Human Services to establish a website with detailed information on the allocation and use of monies in the Prevention and Public Health Fund (PPHF), which was established and funded by ACA Section 4002. • Prohibited the use of PPHF funds for lobbying, publicity, or propaganda purposes.
P.L. 113-6 Mar. 26, 2013	H.R. 933 (Rogers)	<p>Consolidated and Further Continuing Appropriations Act, 2013. Division F, Title V of P.L. 113-6, which provided full-year continuing FY2013 appropriations for Labor-HHS-Education, included the following ACA-related provisions:</p> <ul style="list-style-type: none"> • Rescinded \$200 million of the \$500 million transfer from the Medicare Part A and Part B trust funds for the 5-year Community-Based Care Transition Program, which was established and funded by ACA Section 3026. • Rescinded \$10 million of IPAB's FY2013 appropriation. <p>Note that the PPHF website and the prohibition on using PPHF funds for lobbying, publicity, or propaganda purposes, which were included in P.L. 112-74 (see above), remain in effect in FY2013 under P.L. 113-6.</p>

Source: Prepared by the Congressional Research Service based on the text of the public laws listed in the table.

Author Information

C. Stephen Redhead
Specialist in Health Policy

Edward C. Liu
Legislative Attorney

Jessica Tollestrup
Analyst on Congress and the Legislative Process

Clinton T. Brass
Specialist in Government Organization and
Management

Acknowledgments

Janet Kinzer, Information Research Specialist, helped compile the legislative information in **Table A-1** and **Table A-2** in the appendix.

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.